STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445114	A. BUILDING _____ B. WING _____	05/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRAKEBILL NURSING HOME INC.	5837 LYONS VIEW PIKE KNOXVILLE, TN 37919

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual Recertification survey and complaint investigation (# TN-31550, #TN-31385, and #TN-31543) was completed on May 8, 2013, at Brakebill Nursing Home. Deficiencies were cited under 42 CFR Part 483, Requirements for Long Term Care, related to the annual Recertification survey and complaint # TN -31543.	F 000		6/21/13
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding	F 272	**F 272** **It is the practice of Brakebill Nursing and Rehabilitation Center to conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.** **Corrective Action:** **For resident # 77, a comprehensive assessment was completed by MDS Coordinator on 5/3/2013 with a significant change update on 5/9/2013.** **Identification of other residents having the potential to be affected:** **All residents in the facility were identified as having the potential to be affected by not having a periodically, comprehensive, accurate, standardized, reproducible assessment. Residents identified on review by MDS Coordinator for updated assessments were completed and are now current.** **Measures to be put in place and systemic changes:**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: William M Taylor — TITLE: Administrator — (X6) DATE: 5/24/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	Continued From page 1 the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to complete a comprehensive assessment for one resident (#77) of sixty-four residents reviewed. The findings included: Resident #77 was admitted to the facility on March 17, 2011, with diagnoses including Adult Failure to Thrive, Alzheimer's Disease, Dementia, Congestive Heart Failure, and Atrial Fibrillation. Medical record review of the Minimum Data Set (MDS) revealed the last assessment was completed on December 7, 2012. Further review revealed the facility failed to complete the comprehensive assessment for March 2013. Interview on May 1, 2013, at 8:50 a.m., in the MDS office with MDS Registered Nurse (RN) #2 confirmed the March 2013 MDS had not been completed.	F 272	**MDS Coordinator will maintain a monthly schedule of all residents who are due their periodic updates. An additional full time MDS coordinator, previously part-time, has been added effective April 23, 2013 and assigned to the MDS office to meet the assessment schedules for each resident. In addition, a contract MDS coordinator, previously utilized since March, 2013, has also been extended to ensure all indicated assessments are completed and are timely. Progress will be reported on an ongoing daily basis in morning admission review meeting.** **Monitoring of corrective actions:** **Monitoring of corrections will be a continued, ongoing program utilizing MDS supervisor and MDS coordinators. MDS Supervisor will verify assessment schedules and accuracy of the coordinators by direct observation and chart review in accordance to MDS requirements and assessment schedule. In addition, the Director of Nursing and Administrator will also determine compliance during daily morning meeting and will also utilize direct observation and chart review samplings. All residents will also be reassessed upon a noted decline in ADL's, significant change in mental or physical status, the occurrence of an incident, or if hospitalization is required to address their condition. In addition to reporting MDs and care plan**	
F 275 SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS	F 275		

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F 275	Continued From page 2 A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to complete a comprehensive assessment within 366 days of the prior comprehensive assessment for two (#77, #65) of sixty-four residents reviewed. The findings included: Resident #77 was admitted to the facility on March 17, 2011, with diagnoses including Adult Failure to Thrive, Alzheimer's Disease, Dementia, Congestive Heart Failure, and Atrial Fibrillation. Medical record review of the Minimum Data Set (MDS) revealed the last comprehensive assessment was dated March 14, 2012. Further review revealed the facility failed to complete the comprehensive assessment for March 2013. Interview on May 1, 2013, at 8:50 a.m., in the MDS office with MDS Registered Nurse (RN) #2, confirmed the facility failed to complete the comprehensive assessment due in March 2013. Resident #65 was admitted to the facility on July 3, 2008, with diagnoses including Senile dementia with delirium, Arteriosclerosis, cardiovascular Disease, Hyperlipidemia, Pulmonary Fibrosis, Hypertension, Delusion Disorder, Anxiety, and Convulsions.	F 275	updates during the morning admission meeting, compliance will also be reviewed as an agenda item monthly as a part of the QA/QI process. This process will occur on an ongoing daily and monthly basis. 6/21/13 F 275 Brakebill Nursing and Rehabilitation Center ensures that the facility conducts a comprehensive assessment of a resident not less than once every 12 months Corrective Action: Resident # 77 has received a comprehensive assessment as required. Assessment completed 5/17/2013 by MDS Coordinator on 5/3/2013. Resident # 65 has received a comprehensive assessment as required. Assessment completed 5/17/2013 by MDS Coordinator on 5/2/2013. Identification of other residents having the potential to be affected: Record review by MDS coordinator and DON confirmed that only the residents identified were affected.	

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F 275	Continued From page 3 Medical record review of the Minimum Data Set (MDS) revealed the last comprehensive assessment was dated March 22, 2012. Further review revealed the facility failed to complete the comprehensive assessment for March 2013. Interview on May 8, 2013, at 1:35 p.m., in the MDS office with MDS RN #1 confirmed the facility failed to complete the comprehensive assessment due in March 2013.	F 275	**Measures to be put in place and systemic changes:** **MDS Coordinator will maintain a monthly schedule of all residents who are due their periodic updates. An additional full time MDS coordinator, previously part-time, has been added effective April 23, 2013 and assigned to the MDS office to meet the assessment schedules for each resident. In addition, a contract MDS coordinator, previously utilized since March, 2013, has also been extended to ensure all indicated assessments are completed and are timely.** **Monitoring of corrective actions:** **Monitoring of corrections will be a continued, ongoing program utilizing MDS supervisor and MDS coordinators. MDS Supervisor will verify assessment schedules and accuracy of the coordinators by direct observation and chart review in accordance to MDS requirements and assessment schedule. In addition, the Director of Nursing and Administrator will also determine compliance during daily morning meeting and will also utilize direct observation and chart review samplings. All residents will also be reassessed upon a noted decline in ADL's, significant change in mental or physical status, the occurrence of an incident, or if hospitalization is required to address their condition. In addition to review during the daily morning admission meeting, compliance will also be reviewed monthly as an ongoing monthly agenda item as a part of the QA/QI process beginning 6/1/2013.**	
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within the required three month time frame for two residents (#14, #102) of sixty-four residents reviewed. The findings included: Resident #14 was admitted to the facility on January 14, 2004, with diagnoses including Osteoarthritis, Chronic Ischemic Heart Disease, Full Incontinence, Hypertension, and History of Fall.	F 276		

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F 276	Continued From page 4 Medical record review of the resident's MDS revealed, the last quarterly MDS assessment was completed on December 10, 2012, and the next quarterly MDS assessment was due on March 10, 2013. Interview with the MDS coordinator #2, on May 1, 2013, at 11:10 a.m., in the MDS office, confirmed the March quarterly MDS assessment had not been completed until April 25, 2013. Resident #102 was admitted to the facility on April 6, 2012, with diagnoses including Congestive Heart Failure, Hypertension, Diabetes Mellitus Type 2, Dementia, Psychotic Disorder, and Depression. Medical record review of the resident's last quarterly MDS assessment was completed on January 7, 2013, and the next quarterly MDS assessment was due on April 7, 2013. Interview with the MDS Coordinator #1 on May 7, 2013, at 1:17 p.m., in the MDS office, confirmed the quarterly MDS had not been completed timely as required.	F 276	**F 276** 6/31/13 **Brakebill Nursing and Rehabilitation Center will ensure that the facility will access a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.** **Corrective action that will be accomplished for those residents found to have been affected:** **Resident #14: No opportunity to retro correct assessment date as resident received a quarterly MDS assessment on April 25, 2013.** **Resident # 102: No opportunity to retro correct assessment date as resident received a quarterly MDS assessment on May 10, 2013.** **Identification of other residents having the potential to be affected:**	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.	F 278	**All residents in the facility were identified as having the potential to be affected by not having a periodically, comprehensive, accurate, standardized, reproducible assessment. Residents identified on review by MDS Coordinator for updated assessments were completed by May 31, 2013 and are now current.** **Measures to be put in place and systemic changes:** **MDS Coordinator will maintain a monthly schedule of all residents who are due their periodic updates. An additional full time MDS coordinator, previously part-time, has been added effective April 23, 2013 and assigned to the MDS office to meet the assessment schedules for each resident. In addition, a contract MDS coordinator,**	

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F 278	Continued From page 5 Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to assure each resident receives an accurate assessment by staff who are qualified to assess relevant care areas and knowledgeable about the resident's status, needs, strengths, and areas of decline for three residents (#72, #210, and #123) of sixty four residents reviewed. The findings included: Resident #72 was admitted to the facility on December 10, 2012, with diagnoses including Advanced Alzheimer's Dementia, Osteoarthritis, Dysphagia, and Pneumonia.	F 278	previously utilized since March, 2013, has also been extended to ensure all indicated assessments are completed and are timely. Monitoring of corrective actions: Monitoring of corrections will be a continued, ongoing program utilizing MDS supervisor and MDS coordinators. MDS Supervisor will verify assessment schedules and accuracy of the coordinators by direct observation and chart review in accordance to MDS requirements and assessment schedule. In addition, the Director of Nursing and Administrator will also determine compliance during daily morning meeting and will also utilize direct observation and chart review samplings. All residents will also be reassessed upon a noted decline in ADL's, significant change in mental or physical status, the occurrence of an incident, or if hospitalization is required to address their condition. In addition to review during the morning admission meeting, compliance will also be reviewed as an ongoing agenda item monthly as a part of the QA/QI process. 6/21/13 F 278 Brakebill Nursing and Rehabilitation Center believes that the assessment must accurately reflect the resident's status. Corrective action that will be accomplished for those residents found to have been affected: Resident # 72 as identified in the summary was reassessed by licensed nurse and the	

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F 278	Continued From page 6 Medical record review of the quarterly Minimum Data Set (MDS) dated March 9, 2013, revealed, "...Loss of 5% or more in the last month or loss of 10% or more in last 6 months...(coded as a 1) Yes, on physician-prescribed weight-loss regimen..." Medical record review of the Nutrition Risk Assessment dated December 17, 2012, revealed, "...Wt. (weight) (lb.) (pounds) 157...IBW (Ideal Body Weight)/ usual 90-110...Diet order puree...Overall Risk Category: High..." Medical record review of the appetite/supplement form revealed the resident weighed 157 pounds in December, 2012, and 138.9 pounds in March, 2013. (11.46% weight loss in 3 months) Interview on April 30, 2013, at 8:20 a.m., with Registered Nurse MDS #1, in the training room, confirmed the resident was not on a physician prescribed weight loss regimen and the MDS was coded inaccurately. Resident #123 was admitted to the facility on November 15, 2012, with diagnoses including Abnormality of Gait, Generalized Pain, Aphasia, and Dementia with Behavioral Disturbance. Medical record review of a Significant Change Minimum Data Set (MDS) dated December 26, 2012, revealed the resident had not received Restorative Nursing Services. Medical record review of Plan of Treatment for Outpatient Rehabilitation note not dated revealed, "...Pt (patient) d/c'd (discharged) from PT	F 278	**MDS was corrected and coded correctly by MDS Coordinator on 4/24/2013.** **Resident # 123 was reassessed by licensed nurse and the MDS was corrected to accurately reflect the status of the services received by the resident by MDS Coordinator 4/19; 4/30 and 5/29/2013..** **Resident # 210: MDS assessment was corrected by MDS coordinator to reflect the resident's accurate weights. Residents' weight loss was reviewed by weight loss team and necessary recommendations and interventions were initiated on 5/29/2013.** **Identification of other residents having the potential to be affected:** **Record review by MDS coordinator and DON/ADON confirmed that only the residents identified were affected.** **Measures to be put in place and systemic changes:** **Education and training will be used for new staff upon orientation and scheduled for reinforcement as standard protocol during ongoing staff training and in-services.** **Monitoring of corrective actions:** **Monitoring of corrections will be a continued, ongoing program utilizing shift supervisors and direct observations when**	

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F 278	Continued From page 7 (physical therapy) services on 12/17/12...RNA (Restorative Nursing Assistant) to amb (ambulate) pt as tolerated..." Medical record review of Occupational and Physical Therapy Orders and Treatment Record, dated and signed December 18, 2012, revealed, "...RNA to Amb pt as tol (as tolerarted)..." Interview with MDS Registered Nurse (RN) #2 on May 8, 2013, at 10:48 a.m., in the MDS Office, confirmed the December 26, 2012, MDS did not accurately reflect the status of the services received by the resident. Resident #210 was admitted to the facility on January 22, 2013, with admitting diagnoses of Anemia, Hypertension, Hyperlipidemia, Cerebrovascular Accident, and Dementia. Medical record review of the resident's sixty day MDS assessment revealed the weight recorded was incorrect. The recorded weight was 147 pounds (lbs.), and the actual weight was 138.3 pounds. Review of the facility weight record revealed the resident's admission weight on January 23 ,2013, was 146 lbs.; February 20, 2013, was 143 lbs.; March 19, 2013, was 138 lbs.; and April 23, 2013 was 126 lbs. Interview with MDS coordinator #1 on May 1, 2013, at 10:45 a.m., in the MDS office, confirmed the weight recorded in the nutritional section of the sixty day MDS assessment, dated March 19, 2013, was incorrectly recorded at 147 pounds, and the actual weight was 138.3 pounds,	F 278	**conducting rounds on their designated shifts. MDS Coordinators will also verify accuracy and usage by direct observation and chart review in accordance to MDS requirements and assessment schedule. In addition, the Director of Nursing and Administrator will also determine compliance utilizing direct observation and chart review samplings. All residents will also be reassessed upon a noted decline in ADL's, significant change in mental or physical status, the occurrence of an incident, or if hospitalization is required to address their condition. In addition to the morning admission meeting, MDS assessments and schedules will be reviewed monthly beginning June 1, 2013 as a continuing agenda item as a part of the QA/QI process.**	

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F 278	Continued From page 8 resulting in the MDS assessment not triggering a 6 percent weight loss.	F 278		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to develop a comprehensive care plan for eight residents (#156, #106, #180, #267,#72, #41, #78, and #123) of sixty-four residents reviewed.	F 279	6/21/13 F 279 **Brakebill Nursing and Rehabilitation Centers goal is to ensure that the results from residents assessment is used to develop, review and revise the resident's comprehensive plan of care.** **Corrective action that will be accomplished for those residents found to have been affected:** **Resident #156: Residents care plan had been developed by MDS Coordinator for the use of an indwelling catheter including catheter care and maintenance. Resident has since discharged to a private pay facility where they were on a wait list.** **Resident # 106: Residents care plan updated by MDS Coordinator on 5/21/2013 to reflect and address the resident's use of routine and PRN pain medication for pain management.** **Resident # 267: No opportunity to address or correct as resident expired due to medical conditions and diagnosis.** **Resident # 72: Resident's care plan updated by MDS Coordinator on 5/22/2013 to reflect pain management goals and interventions.**	

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F 279	Continued From page 9 The findings included: Resident #156 was admitted to the facility on November 5, 2012, with diagnoses including Dementia...with Behavioral Disturbances, Rheumatoid Arthritis, Diabetes Mellitus, Coronary Artery Disease with stent, Epilepsy (history of seizures, recent onset) Gastroesophageal Reflux Disease, Osteoporosis, Hypertension, and Irritable Bowel Syndrome. Review of the quarterly minimum data set (MDS) dated February 8, 2013, revealed the resident had an indwelling catheter. Review of the Orders and Progress Notes, Physician's Orders dated December 12, 2012, revealed, "...Foley catheter with routine care until wound heals..." Continued review of the Progress Note dated December 12, 2012, revealed, "...Pt (patient) with sacral wounds so will place foley to help with healing..." Observation on April 29, 2013, at 10:15 a.m., in the resident's room, revealed the resident had an indwelling catheter in place to bedside drainage covered with a privacy bag. Interview with the MDS Coordinator #2 on May 2, 2013, at 8:00 a.m., in the MDS office confirmed the care plan had not been developed for the use of an indwelling catheter including catheter care and maintenance. Resident #106 was admitted on March 3, 2010, with diagnoses including Dementia, Hypertension, Hypothyroidism, Glaucoma, Degenerative Disc Disease, Degenerative Joint Disease, and	F 279	**Resident # 41: A comprehensive care plan was developed by weight team, dietician and MDS Coordinator on 4/24/2013 for nutrition and to address weight loss. Resident has since elected to relocate out of state to be closer to family.** **Resident # 78: A care plan was developed by MDS Coordinator on 6/4/2013 to provide a written plan of care for the residents comfort measures only status.** **Resident # 123: Residents plan of care was updated by MDS Coordinator on 4/12/2013 to address and reflect the use of a lap belt.** **Resident # 180: Residents care plan had been developed by MDS Coordinator on 5/1/2013 for the use of an indwelling catheter including catheter care and maintenance.** **Identification of other residents having the potential to be affected:** **Record review by MDS coordinator and DON confirmed that only the residents identified were affected.** **Measures to be put in place and systemic changes:** **MDS Coordinator will maintain a monthly schedule of all residents who are due their periodic updates. An additional full time MDS coordinator, previously part-time, has been added effective April 23, 2013 and**	

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F 279	Continued From page 10 Osteoporosis. Medical record review of the annual minimum data set (MDS) dated March 10, 2013, revealed the resident scored three out of fifteen on the Brief Interview for Mental Status indicating severe cognitive impairment. Continued review revealed the resident was dependent with one person assist for bed mobility, transfers, dressing, personal hygiene, and bathing. Continued review revealed the resident was on a scheduled pain medication regimen and received PRN (as needed) pain medication or was offered and declined during the assessment period. Continued review revealed the resident described the pain as "moderate." Medical record review of the nurse's note dated April 20, 2013, stated the resident was "...crying out in pain. Gave PRN (as needed) Norco (pain medication) as ordered with good effect noted..." Review of the Physician's Order dated June 8, 2012, revealed, "Pain assessment q (every)shift...document pain rate scale 0-10, intervention and effect of intervention on PRN sheet..." Review of the Medication Record for May 2013, revealed the resident received routine pain medication daily. Continued review revealed physician orders for pain medication Norco 7.5/325 mg (milligrams) 1/2 tab oral every AM (morning); and Norco 1/2 tab oral PRN (evening) q 4 hours for pain. Review of the Medication Record dated May 2013, revealed the resident's pain had been	F 279	**assigned to the MDS office to meet the assessment schedules for each resident. In addition, a contract MDS coordinator, previously utilized since March, 2013, has also been extended to ensure all indicated assessments are completed and are timely. Unit managers will periodically review residents plan of care for accuracy and will update the plan of care upon a noted decline in ADL's, significant change in mental or physical status, the occurrence of an incident, or if hospitalization is required to address their condition. The Director of Nursing and/or designee will report to the MDS coordinator any changes indicated in the resident's plan of care for appropriate updates.** **Monitoring of corrective actions:** **Monitoring of corrections will be a continued, ongoing program utilizing shift supervisors and direct observations when conducting rounds on their designated shifts. MDS Coordinators will also verify accuracy and usage by direct observation and chart review in accordance to MDS requirements and assessment schedule. In addition, the Director of Nursing and Administrator will also determine compliance utilizing direct observation and chart review samplings. All residents will also be reassessed upon a noted decline in ADL's, significant change in mental or physical status, the occurrence of an incident, or if hospitalization is required to address their condition. In addition to the morning admission meeting, MDS assessments and schedules will be reviewed**	

and Care plans will be updated

permission given by Adm on 6/10/13 11:10AM to add information

MA Kylie PNHC II

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445114	A. BUILDING _____ B. WING _____	05/08/2013

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F 279	Continued From page 11 monitored every shift and recorded on this record. Observation and interview with the resident on April 29, 2013, at 10:37 a.m., in the resident's room revealed the resident rolled self toward the left rail to relieve pressure on the buttocks, and stated "...my bottom is getting sore..." Interview with MDS Coordinator #2 in the MDS office on May 1, 2013, at 8:00 a.m., confirmed the resident's care plan dated March 30, 2013, did not address the resident's use of routine and PRN pain medication for pain management. Resident #180 was re-admitted to the facility on March 25, 2013, (following an acute hospitalization) with diagnoses including Severe Chronic Obstructive Pulmonary Disease, Depression, Recurrent Urinary Tract Infections and Urinary Retention. Medical record review of the resident's Minimum Data Set assessment, dated January 26, 2013, revealed the resident was alert with mild cognitive impairment, required extensive staff assistance with transfers and hygiene, was ambulatory by wheelchair, and the resident was "...always continent..." of bowel and bladder. Medical record review of the resident's comprehensive care plan dated April 2013, revealed no plan of care for the use of an indwelling urinary catheter, and no interventions related to care and maintenance of the indwelling catheter had been addressed. Observation and interview with the resident on April 30, 2013, at 1:10 p.m., revealed the resident	F 279	as an agenda item monthly as a part of the QA/QI process. Beginning June 1, 2013 permission given by Adm. on 6/10/13 11:10 am to acted above date. MA Bylie PHNC-II	

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F 279	Continued From page 12 alert and sitting in a wheelchair in own room. The resident stated the urinary catheter had been placed during hospitalization and an appointment with a urinary specialist was pending in May, due to intermittent urinary retention. Interview with LPN #6 on April 30, 2013, at 10:30 a.m., at the 100 hall nurse's station, confirmed the resident had an indwelling foley catheter, and the care plan had not been updated to address the device and/or it's care. Interview with the acting Director of Nursing on May 6, 2013, in the training room, confirmed the facility failed to revise the resident care plan to include a urinary catheter present on readmission to the facility March 25, 2013. Resident #267 was admitted to the facility on April 10, 2013, with diagnoses including Diabetes Mellitus Type II, Congestive Heart Failure, Hypertension, and Dementia. Observations revealed the resident had an indwelling urinary catheter on the following dates: April 29, 2013, at 10:52 a.m., April 30, 2013, at 8:26 a.m., May 1, 2013, while in bed; and May 1, 2013, at 3:33 p.m., May 7, 2013, at 3:40 p.m., and May 8, 2013, at 8:35 a.m., while in a wheel chair. Medical record review of the nursing note dated April 10, 2013, revealed "...foley catheter attached to leg..." Medical record review of the interim care plan dated April 11, 2013, revealed the foley catheter had not been addressed.	F 279		

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F 279	Continued From page 13 Interview on May 8, 2013, at 9:45 a.m., in training room, with the Assistant Director of Nursing, confirmed the facility had not addressed the catheter on the care plan dated April 11, 2013. Resident #72 was admitted to the facility on December 10, 2012, with diagnoses including Advanced Alzheimer's Dementia, Osteoarthritis, Dysphagia, and Pneumonia. Medical record review of the Physician's Recapitulation Orders dated April 1, 2013, through April 30, 2013, revealed "...Morphine Sulfate (pain medication) 4 mg (milligrams) subcutaneous at bedtime...Morphine 4mg every 2 hours may repeat (times one) subcutaneous prn (as needed)..." Medical record review of the care plan dated December 11, 2012, revealed no documentation of pain management with goals and interventions. Observation on May 1, 2013, at 3:15 p.m., revealed the resident was seated in a broda chair in the resident's room. Interview on May 1, 2013, at 10:55 a.m., in the training room, with the acting Director of Nursing (DON) confirmed the care plan had not been developed to include pain management. Resident #41 was admitted November 7, 2012, with diagnoses of Subdural Hematoma status post fall, Dementia, Depression, Deep Vein Thrombosis, and Hypertension. Medical record review of the resident's care plan	F 279		

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F 279	Continued From page 14 revealed no nutritional comprehensive care plan had been developed. Interview with the acting Assistant Director of Nursing on May 7, 2013, at 2:45 p.m., in the training room, confirmed no comprehensive care plan for nutrition had been developed, and the resident had experienced a significant weight loss. Resident #78 was admitted to the facility on June 22, 2012 with diagnoses including Dementia, Epilepsy, Depression, Dysphagia, and Affective Psychosis. Medical record review of a physician's order dated and signed November 28, 2012, revealed, "...Make pt (patient) CMO (comfort measures only), DNR (do not resuscitate)...no labs or IV's (intravenous therapy), no Xry (X-rays), PO (oral) antibiotics only..." Medical record review of the resident's care plan last reviewed April 29, 2013, revealed, "...Advance Directives: DNR..." Continued review of the resident's care plan revealed, "...Interventions...Follow advanced directives per POST (Physician's Orders for Scope of Treatment) form..." Medical record review of the resident's POST form signed and dated by the physician on November 28, 2012, revealed, "...Comfort Measures ...No labs, no x-rays, no UA (urinalysis), no IV's..." Interview with the acting Director of Nursing (DON) on May 7, 2013, at 9:08 a.m., in the	F 279		

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F 279	Continued From page 15 training room, confirmed the facility failed to develop a written plan of care for the resident's comfort measures only status. Resident #123 was admitted to the facility on November 15, 2012, with diagnoses including Abnormality of Gait, Generalized Pain, Aphasia, and Dementia with Behavioral Disturbance. Medical record review of the Quarterly Minimum Data Set (MDS) dated February 20, 2013, revealed the use of a physical restraint. Medical record review of Pre-Restraining Evaluation form dated April 2, 2013, revealed, "...w/c (wheelchair) with...self-release belt..." Medical record review of the resident's care plan, last updated April 12, 2013, revealed, "...Resident at risk for falls secondary to d/t (due to) hx (history) of 5 recent falls, unsteady gait and balance and poor safety awareness..." Continued review of the resident's care plan revealed interventions to prevent falls "...psa (personal safety alarm) to low bed et (and) w/c (wheelchair)...w/c with self-release lap belt..." Further review of the resident's care plan revealed no care plan for the use of the lap belt restraint. Interview with the acting DON on May 8, 2013, at 9:00 a.m., in the Training Room, confirmed the self-release lap belt was a physical restraint, and confirmed a care plan had not been initiated for the use of a physical restraint.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280	F 280 Brakebill Nursing and Rehabilitation Center believes the resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning of care and treatment or changes in care and treatment.	6/21/13

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F 280	Continued From page 16 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record reviews, observations and interviews, the facility failed to update and revise resident care plans to reflect the residents current status, treatments, and care needs for four residents (#77, #123, #115, and #210) of sixty-four residents reviewed. The findings included: Resident #123 was admitted to the facility on November 15, 2012, with diagnoses including Abnormality of Gait, Generalized Pain, Aphasia, and Dementia with Behavioral Disturbance.	F 280	**Corrective action that will be accomplished for those residents found to have been affected:** **Resident # 123: The residents care plan was updated by MDS Coordinator on 5/16/2013 to reflect the resident's most recent fall and resident was reviewed by IDT members for additional interventions as indicated.** **Resident # 115: No opportunity to correct residents previous care plan. Residents care plan was updated on April 25, 2013 by MDS Coordinator to reflect weight loss interventions.** **Resident # 210: Residents care plan has been updated by MDS Coordinator on 4/23/2013to reflect weight loss interventions ordered on April 23, 2013.** **Resident # 77: Residents care plan has been reviewed by weight loss team members consisting of DON, ADON, RNA, Medical Records Coordinator, RD, and MDS Assistant and updated by MDS Coordinator on 5/3/2013 to reflect weight loss interventions.** **Identification of other residents having the potential to be affected:** **An MDS audit by Director of Nursing and MDS Coordinator(s) revealed no other residents as being affected.** **Measures to be put in place and systemic changes:**	

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F 280	Continued From page 17 Medical record review of the Quarterly Minimum Data Set (MDS) dated February 20, 2013, revealed the resident was severely cognitively impaired and required extensive assistance with all activities of daily living (ADLs). Medical record review of the resident's care plan, last updated April 12, 2013, revealed, "...Resident at risk for falls secondary to d/t (due to) hx (history) of 5 recent falls, unsteady gait and balance and poor safety awareness..." Continued review of the resident's care plan revealed interventions to prevent falls "...psa (personal safety alarm) to low bed et (and) w/c (wheelchair)...monitor visually frequently...toilet per plan ..." Medical record review of the nurse's note dated April 27, 2013, revealed, "...alarm sounding observed resident lying in floor on R (right) side near restroom pads on floor low bed in use d/t confusion per usual...brief was soiled...0 (no)...injury ..." Interview with the acting Director of Nursing (DON) on May 8, 2013, at 9:00 a.m., in the training room, confirmed the resident had a fall without injury on April 27, 2013, and the resident's care plan had not been updated to reflect the resident's most recent fall. Resident #115 was admitted to the facility on November 1, 2011, with admitting diagnoses of Care Involving use of Rehabilitative Procedures, Parkinson's Disease, Paralysis Agitans, Chronic Kidney Disease, Essential Hypertension, and Depressive Disorder.	F 280	MDS Coordinator will maintain a monthly schedule of all residents who are due their periodic updates. An additional full time MDS coordinator, previously part-time, has been added effective April 23, 2013 and assigned to the MDS office to meet the assessment schedules for each resident. In addition, a contract MDS coordinator, previously utilized since March, 2013, has also been extended to ensure all indicated assessments are completed and are timely. Unit managers will periodically review residents plan of care for accuracy and will update the plan of care upon a noted decline in ADL's, significant change in mental or physical status, the occurrence of an incident, or if hospitalization is required to address their condition. The Director of Nursing and/or designee will report to the MDS coordinator any changes indicated in the resident's plan of care for appropriate updates. Monitoring of corrective actions: Monitoring program will be applied under the same conditions as cited in F Tags listed above utilizing the same criteria as noted. Monitoring of corrections will be a continued, ongoing program utilizing shift supervisors and direct observations when conducting rounds on their designated shifts. MDS Coordinators	

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F 280	Continued From page 18 Medical record review of the resident's care plan dated November 2, 2012, revealed no interventions were implemented after a significant weight loss of seven percent from January through March 2013. Interview with Licensed Practical Nurse (LPN) #2 on May 1, 2013, at 7:46 a.m., at the 400 hall nurse's station, confirmed the resident's care plan had not been updated to reflect any weight loss interventions, no interventions had been put in place until April 25, 2013. Resident #210 was admitted to the facility on January 22, 2013, with admitting diagnoses of Anemia, Hypertension, Hyperlipidemia, Cerebrovascular Accident, and Dementia. Medical record review of the resident's care plan revealed ,"... Potential for Weight Loss..." dated January 23, 2013, had not been updated to reflect the resident's significant weight loss, and no new interventions were ordered to prevent weight loss. Interview with Assistant Director of Nursing (ADON) at the 200 hall nurse's station on May 1, 2013, at 8:42 a.m., confirmed the resident's care plan had not been updated to reflect weight loss interventions ordered on April 25, 2013. Resident #77 was admitted to the facility on March 17, 2011, with diagnoses including Adult Failure to Thrive, Alzheimer's Disease, Dementia, Congestive Heart Failure, Atrial Fibrillation, and Symptoms Concerning Nutrition, Metabolism. Medical record review of the Quarterly Minimum Data Sets (MDS) dated September 10, 2012, and	F 280	**MDS Coordinator will maintain a monthly schedule of all residents who are due their periodic updates. An additional full time MDS coordinator, previously part-time, has been added effective April 23, 2013 and assigned to the MDS office to meet the assessment schedules for each resident. In addition, a contract MDS coordinator, previously utilized since March, 2013, has also been extended to ensure all indicated assessments are completed and are timely. Unit managers will review a sample of 20% of units' residents' plan of care for accuracy weekly for 8 weeks for compliance and once per month thereafter if compliance is achieved. Unit manager and MDS Coordinator will update the plan of care upon a noted decline in ADL's, significant change in mental or physical status, the occurrence of an incident, or if hospitalization is required to address their condition. The Director of Nursing and/or designee will report to the MDS coordinator any changes indicated in the resident's plan of care for appropriate updates.** **Monitoring of corrective actions:** **Monitoring of corrections will begin June 1, 2013 by Unit managers and MDS staff will be a continued, ongoing program utilizing shift supervisors and direct observations when conducting rounds on their designated shifts. MDS Coordinators will also verify accuracy and usage by direct observation and chart review in accordance to MDS requirements and assessment schedule. In**	

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F 280	Continued From page 19 December 7, 2012, revealed the resident was severely cognitively impaired, required extensive assistance with one person physical assistance for eating, and had no weight loss or gain. Medical record review of the nutritional progress note dated December 2, 2012 revealed the resident was not able to self.feed and the Ideal Body Weight range was 81-99#. Review of the weight record revealed the following weights: 1. January 25, 2013, weight 85.8 pounds (#). 2. February 26, 2013, weight 84.1#. 3. March 21, 2013, weight 79.6#. 4. April 25, 2013, weight 74#, for a 5.6# loss or 7% in 30 days from the March 21, 2013 weight. Review of the physician orders revealed the following: 1. March 26, 2013, Nutritional supplement three times daily due to weight loss; 2. April 2013 Recapitulation Orders signed by the physician April 23, 2013, diet order No Added Salt, Mechanical Soft (texture), Chopped Meat, High Calorie Orange Beverage three times daily and Nutritional supplement 2 ounces three times a day. 3. April 25, 2013, add buttermilk three times daily with meals, and weekly weights for four weeks. Medical record review of the Plan of Care dated March 15, 2012, revealed a problem of "...Potential for dehydration and wt (weight)loss d/t (due to) po (by mouth) fluctuation, requires total feeding with the APPROACHES: Enc (Encourage) 75-100% of diet, place in upright position for all meals, give bite of food and follow	F 280	addition, the Director of Nursing and Administrator will also determine compliance utilizing direct observation and chart review samplings. All residents will also be reassessed and care plan updated upon a noted decline in ADL's, significant change in mental or physical status, the occurrence of an incident, or if hospitalization is required to address their condition. In addition to the morning admission meeting, MDS assessments, care plans and schedules will be reviewed monthly as an agenda item as a part of the QA/QI process.	

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F 280	Continued From page 20 with sip of liquid...offer subs (substitutes) for food refused, food preferences...enc po fluids...monitor weights and intake and document in chart...offer snacks and supplements as ordered..." Further review of the care plan revealed no changes to the problem or approaches since March 15, 2012. Interview with the acting Director of Nursing (DON) and the Medical Record Director on April 30, 2013, at 4:12 p.m., in the training room, confirmed the March 2013, and April 2013, Medication Administration Record did not have documentation of the nutritional supplement administration. Further interview revealed the weight loss meeting stopped in February 2013 and resumed April 25, 2013. Interview with MDS Registered Nurse #2 on May 1, 2013, at 8:50 a.m., in the training room, confirmed "...Aware care plans behind..." Interview with the acting DON on May 7, 2013, at 2:25 p.m. in the training room, confirmed the weight loss had not been addressed on the care plan at the time of the loss in January, February, and March, 2013.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the Drug Information Handbook for Nursing (2007), review of facility policy, and interview, the facility	F 281	F 281 It is the goal of Brakebill Nursing and Rehabilitation Center to ensure the services provided or arranged by the facility will meet professional standards of quality. Corrective action that will be accomplished for those residents found to have been affected:	6/21/13

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F 281	Continued From page 21 failed to follow facility protocol and physician order's for the treatment of constipation and failed to monitor for side-effects of an antipsychotic medication for one resident (#123), and failed to follow physician's orders for documentation of intake and output for one resident (#143) of sixty-four residents reviewed. The findings included: Resident #123 was admitted to the facility on November 15, 2012, with diagnoses including Abnormality of Gait, Generalized Pain, Aphasia, and Dementia with Behavioral Disturbance. Medical record review of the Quarterly Minimum Data Set (MDS) dated February 20, 2013, revealed the resident had received an anti-anxiety medication, an antipsychotic medication, and was on a scheduled pain medication regimen. Medical record review of the resident's Medication Administration Record (MAR) for the month of May, 2013, revealed the resident had received Klonopin (anti-anxiety medication), Seroquel (antipsychotic medication), MS Contin (narcotic pain medication), Morphine IR (narcotic pain medication), and Lortab (narcotic pain medication) on a daily basis. Review of Drug Information Handbook for Nursing (2007) revealed the anti-anxiety medication, the antipsychotic medication, and the narcotic pain medications all had an increased risk for constipation. Medical record review of the resident's ADL (activities of daily living) Flow Record for the	F 281	**Resident # 123: Resident received treatment related to constipation on May 5, 2013. AIMS Scale assessment and documentation by Psychiatric PhD related to antipsychotic medications have been addressed and follow-up scheduled with Psychiatric PhD in normal course of residents on-going treatment.** **Resident # 143: Current intake and output is now addressed and documented according to physicians order.** **Identification of other residents having the potential to be affected:** **Record review of residents receiving antipsychotic medications, orders for monitoring of intake and output was conducted by Unit managers and/or psychiatric PhD was reviewed. No problems were identified.** **Measures to be put in place and systemic changes:** **Residents receiving antipsychotic medications and/or receiving psychiatric treatment by Psychiatric PhD will be reviewed for AIMS testing by unit managers. Director of Nursing and/or Assistant Director will conduct in-services for all nursing staff regarding monitoring**	

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F 281	Continued From page 22 month of May, 2013, revealed designated spaces for the documentation of bowel function per shift. Continued review of the ADL Flow Record for the month of May, 2013, revealed no documentation the resident had a bowel movement from May 1, 2013, until May 5, 2013, for a total of four days. Medical record review of the resident's MAR for the month of May, 2013, revealed "...laxative given to promote BM (bowel movement)..." signed and dated May 5, 2013, at 2:00 p.m. Medical record review of Routine Orders signed and dated November 16, 2012, revealed, "...3. Constipation ...Dulcolax (5) milligram tablet or (10) milligram suppository, daily times (2) days or Milk of Magnesia (30) milliliters daily times (2) days..." Interview with Licensed Practical Nurse (LPN) #8 on May 7, 2013, at 3:48 p.m., at Green Wing 300 Hall Nurse Station, revealed facility protocol for treatment and management of constipation is after three days of no documented bowel movement then Milk of Magnesia (MOM) should be given and if no result then suppository is to be given. Interview with LPN #8 on May 8, 2013, at 10:11 a.m., in 300 hallway, confirmed the ADL Flow Record for the resident had no documentation the resident had a bowel movement until May 5, 2013, on the evening shift. Further interview with LPN #8, at that time, confirmed the resident was at high risk for constipation "...because (the resident) is on multiple pain meds..." Continued interview with LPN #8, confirmed the nurses monitor the resident's bowel function by reviewing	F 281	**and documentation of bowel movements and documentation requirements relating to intake and output requirements on residents with specified physician orders. In-services will be conducted within the 45 day period allowed in the 2567 or by June 22, 2013.** **Monitoring of corrective actions:** **Unit managers and/or shift supervisors will be responsible foe ensuring adherence to documentation requirements. Log will be maintained by social services for those residents receiving psychiatric services. Director of Nursing and/or Assistant or unit manages will monitor a sample of 20% of units' residents' weekly for 8 weeks for compliance and once per month thereafter if compliance is achieved. In-service training will be used to educate Cna's on requirement to adhere and report any deviations in bowel policy requirements to licensed nursing staff for appropriate interventions.** **In-services will be conducted by the DON/ADON within the 45 day period allowed in the 2567 or by June 22, 2013.** **Psychiatric services log management will be reviewed monthly in the QA/QI meeting in addition to MDS resident listing to monitor residents receiving antipsychotic medications or who are being monitored for I&O.**	

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F 281	Continued From page 23 the ADL Flow Record. Further interview with LPN #8, confirmed the resident had not received treatment for constipation until the fifth day of no recorded bowel movement, and the facility protocol for management and treatment for constipation had not been followed. Medical record review of the Quarterly Minimum Data Set (MDS) dated February 20, 2013, revealed the resident had received an antipsychotic medication. Medical record review of the resident's MAR revealed the resident had received Seroquel (an antipsychotic medication) 50 mg at 4 p.m. and at bedtime on a daily basis. Medical record review of an Abnormal Involuntary Movement Scale (AIMS), a scale to monitor for the presence of potentially permanent side-effects of an antipsychotic medication, revealed no documentation for the AIMS scale in the medical record. Interview with the Assistant Director of Nursing (ADON) and Psychiatric PhD on May 7, 2013, at 3:53 p.m., at the 200 Hallway nurse station, confirmed the facility policy for monitoring of side-effects of antipsychotic medication should be completed on every resident upon admission to the facility. Continued interview with the ADON and Psychiatric PhD, at that time, confirmed the AIMS scale should be completed at least two times per year after admission to the facility. Interview with the Acting Director of Nursing (DON) on May 8, 2013, at 9:00 a.m., in the Training Room, confirmed the AIMS form was not	F 281		

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F 281	Continued From page 24 completed for the resident upon admission to the facility. Further interview with the DON also confirmed the AIMS scale had not been completed at any time during the resident's stay at the facility. Continued interview with the DON confirmed the resident should have had an AIMS completed at least once since the resident's admission to the facility, and confirmed the facility's protocol for monitoring of an antipsychotic medication had not been followed. Resident #143 was admitted to the facility on March 19, 2013 with diagnoses including Congestive Heart Failure, Pneumonia, and Dementia. Medical record review of a physician's order dated April 17, 2013, revealed an order for "...Strict I & O (intake and output)..." Medical record review of the resident's Intake Output Record revealed multiple blank spaces over various shifts for the documentation of the resident's intake. Review of facility Policy and Procedure for Intake and Output revealed, "...Intake and output will be recorded accurately on any resident with specific order or when medically indicated..." Continued review of facility policy revealed, "...any resident with specific physician order for Intakes and Outputs (I&O) will have them recorded q (every) eight hours regardless..." Interview with the acting DON on May 1, 2013, at 8:28 a.m., in the training room, confirmed the resident's intake was not consistently documented in the medical record. Continued	F 281		

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F 281	Continued From page 25 interview with the DON, at that time, confirmed the facility's policy for documenting intake, and the physician's order for documenting and monitoring intake had not been followed.	F 281		6/21/13
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide restorative nursing services as ordered for one resident (#123) of sixty-four residents reviewed. The findings included: Resident #123 was admitted to the facility on November 15, 2012, with diagnoses including Abnormality of Gait, Generalized Pain, Aphasia, and Dementia with Behavioral Disturbance. Medical record review of Quarterly Minimum Data Set (MDS) dated February 20, 2013, revealed the resident was severely cognitively impaired and required extensive assistance with all activities of daily living (ADLs). Medical record review of Plan of Treatment for Outpatient Rehabilitation note, not dated, revealed, "...Pt (patient) d/c'd (discharged) from PT (physical therapy) services on 12/17/12...RNA (Restorative Nursing Assistant) to amb (ambulate) pt as tolerated..."	F 311	**F 311** **Brakebill Nursing and Rehabilitation Center subscribes to the standard that a resident is given the appropriate treatment and services to improve his or her abilities.** **Corrective action:** **Resident # 123: Resident was admitted to facility as indicated on November 15, 2012 with a diagnosis including abnormality of Gait, Generalized Pain, Aphasia, Dementia with Behavioral Disturbances, Severe Cognitive Impairment and Extensive Assistance with all Activities of Daily Living. Resident received Physical Therapy services but was discharged from their services on 12/17/2012 due to meeting their maximum potential and inability to benefit from further treatment. Resident was discharged to Restorative Nursing Services to ambulate patient as tolerated. Physical Therapy orders and treatment Record dated and signed December 18, 2012 stated " RNA to AMB pt as tol (tolerated)". No specific time frames or frequency was indicated other than "as tolerated" due to residents advanced diagnosis as listed. During this period of time resident exhibited increased behavioral episodes of combative behavior, inconsolable episodes of anger and anxiety, refusal of medications and**	

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F 311	Continued From page 26 Medical record review of Occupational and Physical Therapy Orders and Treatment Record, dated and signed December 18, 2012, revealed, "...RNA to Amb pt as tol (as tolerarted)..." Medical record review of Daily Patient Service Record Restorative for the month of December, 2012, revealed the resident received restorative services for ambulation on one day, December 20, 2012, out of nine days. Medical record review of Daily Patient Service Record Restorative for the month of January, 2013, revealed the resident received restorative services for ambulation on four days out of twenty-two days. Medical record review of Daily Patient Service Record Restorative for the month of February, 2013, revealed the resident received no restorative services for ambulation for the entire month. Interview with Restorative Nursing Assistants #1 and #2 on May 8, 2013, at 9:21 a.m., in the Training Room, confirmed the Daily Patient Service Record Restorative for the months of December, 2012, January, 2013, and February, 2013 accurately reflected the number of restorative services the resident had received for those months. Continued interview with Restorative Nursing Assistants #1 and #2, at that time, confirmed the resident had not received restorative nursing services as ordered.	F 311	**numerous visits by family to intervene. Resistance to care is also noted and documented. Physician interventions are also noted with the addition of Tramadol, Klonapin, and increased pain management including morphine. This combination of factors would account for resident's inability to want or receive RNA services during the time frame indicated. Resident is now capable of participate in RNA services and is now receiving services since March 2013.** **Identification:** **On record review by DON & therapy manager, no other residents were identified.** **Measures to be put in place and systemic changes:** **No specific or systemic changes are indicated or warranted in the system at this time due to resident's lack of ability to participate in RNA services.** **Monitoring of corrective actions:** **Monitoring of corrective actions is not indicated due to resident's history, severe condition and uncontrollable behaviors during this period of time. Resident was receiving extensive medical and psychiatric treatment for exhibited conditions and diagnosis. Resident is now receiving services**	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		

permission given by Adm on 6/10/13 11:10am to add to F 311:
when a residents' condition changes where a resident can't or won't participate in rehab, Restorative will be put on hold and restarted when the resident can participate.
Monitoring: Restorative services will monitor any residents who are put on hold to ensure services are resumed when resident can participate.
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F 312	Continued From page 27 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to maintain personal hygiene for one resident (#150) of sixty-four residents reviewed. The findings included; Resident #150 was admitted to the facility on August 21, 2008, with diagnoses including Adult Failure to Thrive, Hypertension, Osteoporosis, Vertigo, and History of Falls. Medical record review of the quarterly minimum data set dated December 16, 2012, revealed the resident scored twelve out of fifteen on the Brief Interview for Mental Status indicating moderate cognitive impairment. Continued review revealed the resident required extensive assistance from one person for transfers, dressing, personal hygiene, toileting, and bathing. Review of the resident's care plan dated September 18, 2012, revealed, "...Resident with self-care deficits secondary to limited ambulation and falls risk...Interventions...Clean fingernails with shower; clip fingernails q (every) 2 weeks..." Review of the facility's, Policy for Nail Care, revealed, "It is the policy of (facility name) that all	F 312	according to " RNA to AMB pt as tol (tolerated)" order. Future refusals by resident will be documented by RNA services. F 312 Brakebill Nursing and Rehabilitation Center supports the standard that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral care. Corrective action: Resident # 150: Residents finger nails were cleaned and trimmed during the shift condition was noted by a licensed nurse. Interview with resident revealed this was an isolated incident as resident confirmed "the staff usually trimmed the fingernails when they needed trimming". Identification: Based on observation by nursing staff, no other resident was noted or identified as being effected.	6/21/13

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F 312	Continued From page 28 nail care will be provided by a License nurse. All fingernails will be clipped every two (2) weeks, and toenails clipped every month." Observation on April 29, 2013, at 3:50 p.m., of the resident seated in a chair in the resident's room revealed the resident 's fingernails were long, jagged, and had brown debris under the nails. Interview with the resident at this time confirmed the staff usually trimmed the fingernails when they needed trimming, and the nails "...could use a little trimming..." Observation and interview with Licensed Practical Nurse (LPN) #6 on May 6, 2013, at 8:45 a.m., in the resident's room revealed the resident's fingernails were long and had brown debris under the nails. Continued interview with LPN #6 confirmed the nails were "...nasty and needed to be soaked and trimmed..."	F 312	**Measures to be put in place and systemic changes:** **Directed In-service Indicated. Director of Nursing/Assistant director of Nursing will in service all direct care staff to monitor and report to licensed nursing staff any resident in need of nail care. Cna's will visually note condition of residents nails during scheduled shower times and report any observations needing care. In-services will be conducted within the 45 day period allowed in the 2567 or by June 22, 2013.** **Monitoring of corrective actions:** **Monitoring for compliance will consist of Cna observation and reporting during administration of personal care and during residents shower times. Licensed nurses will also ensure compliance using direct observation during daily medication passes. The Director of Nursing and/or unit managers will observe a 15% sample of residents on each hall for 8 weeks for compliance. If compliance is indicated, sample will consist of 10 % of unit's resident population on a monthly basis thereafter. Compliance will be reviewed monthly during the QA/QI meeting beginning 6/1/2013.**	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder	F 315		

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F 315	Continued From page 29 function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility policy, observation, and interview, the facility failed to complete a bladder assessment for one (#254) resident, failed to obtain a physician order and a supporting diagnoses for a catheter for one (#267) resident and failed to remove an indwelling urinary catheter for one (#156) resident of sixty-four residents reviewed. The findings included: Resident #254 was admitted to the facility on January 11, 2013, with diagnoses including Diabetes, Pneumonia, Hypertension, and Dementia. The resident expired at the facility on February 6, 2013. Medical record review of the Admission Minimum Data Set (MDS) dated January 18, 2013, revealed the resident had moderately impaired cognitive skills, and was frequently incontinent of urine. Medical record review of the Significant Change in Status MDS dated February 1, 2013, revealed the resident was always incontinent of urine. Medical record review of the Admission Assessment dated January 11, 2013, revealed "...Resident is a potential candidate for nursing, restorative/rehabilitation, or bladder training program..."	F 315	**F 315** **Brakebill Nursing and Rehabilitation Center supports the standard that based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much as normal bladder function as possible.** **Corrective Action:** **Resident # 254: No opportunity to correct and/or address as resident expired February 6, 2013.** **Resident # 267: No opportunity to address or correct as resident expired due to medical conditions and diagnosis.** **Resident: # 156: Resident's indwelling catheter was removed by nursing staff on 4/30/2013 following confirmation of healing of wound by therapy manager according to physician orders.** **Identification:** **Based on medical record review and observation by licensed nursing staff and/or unit managers, no other residents were noted or identified as being effected.**	6/21/13

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F 315	Continued From page 30 Medical record review of the care plan dated February 1, 2013, revealed "...Resident with B (and) B (bowel and bladder) incontinence...check and change: upon rising; before and/or after meals; at HS (bedtime); and Q (every) 2-3 hrs (hours) during sleep hrs..." Review of the facility policy, Bowel and Bladder Training, (undated) revealed, "...Take the resident to toilet or bed pan at every 2-hour interval. Time may be lengthened as control is gained. Encourage residents to hold urine until specified voiding time, if possible, and they get protocol for assessing bowel and bladder continence status..." Interview on May 1, 2013, at 2:00 p.m., with the acting Director of Nursing (DON), in the training room, confirmed no bladder assessment had been completed to determine if the resident was appropriate for an individualized bladder training program. Interview on May 1, 2013, at 3:50 p.m. with the acting Assistant Director of Nursing (ADON), in the hall, confirmed bowel and bladder assessments are to be done on admission, quarterly and with a significant change in the resident's status. Resident #267 was admitted to the facility on April 10, 2013, with diagnoses including Diabetes Mellitus Type II, Congestive Heart Failure, Hypertension, Dementia, and Urinary Incontinence. Observations revealed the resident had a catheter on the following dates: April 29, 2013, at	F 315	**Measures to be put in place and systemic changes:** **Directed In-service Indicated. Director of Nursing/Assistant director of Nursing will in service all direct nursing staff regarding completion of a bladder assessment and obtaining a physician's order with supporting diagnosis for use of an indwelling catheter. Staff will also receive in-service training by DON/ADON regarding the removal of indwelling catheters according to physician orders. In-services will be conducted within the period allowed in the 2567 or no later than June 22, 2013.** **Monitoring of corrective actions:** **Monitoring for compliance will be accomplished by identification of residents on each nursing unit by unit managers and/or supervisors. The MDS listing of residents with a catheter will be utilized to monitor resident's code as having an indwelling catheter to ensure continuity of care and review of physicians orders regarding catheter care. The Director of Nursing and/or ADON and MDS Coordinator will review coding of residents with indwelling catheters during weekly care plan meeting and verify validity of bladder assessments, physician orders, supporting diagnosis and adherence to physician orders for continued use. Review of 672 for conditions of residents will be**	

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F 315	Continued From page 31 10:52 a.m., April 30, 2013, at 8:26 a.m., May 1, 2013, at 8:32 a.m., while in bed; and May 1, 2013, at 3:33 p.m., May 7, 2013, at 3:40 p.m., and May 8, 2013, at 8:35 a.m., while in a wheel chair. Medical record review of the nursing note dated April 10, 2013, revealed "...foley catheter attached to leg..." Medical record review of the physician orders dated April 10, 2013 through May 8, 2013, revealed no orders for a catheter. Medical record review of the Resident Data Set, completed by a nurse, dated April 10, 2013, of the" Indwelling Catheter Evaluation" revealed the resident was not in a coma, was not terminally ill, did not have a stage 3 or 4 pressure ulcer, did not have a diagnosis of urethral blockage, did not need an exact measurement of urine, did not have a history of being unable to void after the catheter was removed, was not a quadriplegic or paraplegic, and did not have an appropriate supportive diagnosis. Further review revealed "...All questions were marked "No" and there is no appropriate diagnosis. The resident is a potential candidate for nursing, restorative/rehabilitation, or bladder training program..." Further review of the Resident Data Set revealed the urological section was not completed. Interview on May 7, 2013, at 4:45 p.m., at the 400 nursing station with Licensed Practical Nurse (LPN) #10 and LPN #11, confirmed there was no order for a catheter. Interview on May 8, 2013, at 9:45 a.m., in training	F 315	reviewed monthly during the QA/QI meeting beginning 6/1/2013.	

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F 315	Continued From page 32 room, with the Assistant Director of Nursing confirmed the facility had no policy addressing catheters. Further interview confirmed no diagnosis to support a catheter upon admission, and no physician order for the catheter at admission April 10, 2013, through May 8, 2013. Resident #156 was admitted to the facility on November 5, 2012, with diagnoses including Dementia...with Behavioral Disturbances, Rheumatoid Arthritis, Diabetes Mellitus, Coronary Artery Disease with stent, Epilepsy (history of seizures, recent onset) Gastroesophageal Reflux Disease, Osteoporosis, Hypertension, and Irritable Bowel Syndrome. Review of the Orders and Progress Notes, Physician's Orders dated December 12, 2012, revealed, " ...Foley catheter with routine care until wound heals ..." Continued review of the Progress Note dated December 12, 2012, revealed, " ...Pt (patient) with sacral wounds so will place foley to help with healing ..." Observation on April 29, 2013, at 10:15 a.m., in the resident's room, revealed the resident had an indwelling catheter in place connected to bedside drainage and covered with a privacy bag. Interview with the wound management/physical therapist in the training room on May 1, 2013, at 8:40 a.m., confirmed the resident had been admitted with wounds to the coccyx area on November 5, 2012. Continued interview confirmed the physician ordered the catheter to decrease moisture to the wound area to expedite wound healing. Continued interview confirmed the wounds on the coccyx area were healed by	F 315		

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F 315	Continued From page 33 December 26, 2012, monitored for one week after the 26th to ensure healing, and removed from monitoring. Interview on May 1, 2013, at 12:30 p.m., with Licensed Practical Nurse (LPN) #6 on the 100 hallway confirmed the resident's wounds to the coccyx area had been healed, and the physician's order to discontinue the catheter when wounds were healed had not been followed.	F 315		
F 325 SS=E	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to assess, implement, monitor, and modify interventions, consistent with the resident's needs to maintain acceptable parameters of nutritional status for five residents (#'s 41, 77, 156, 159, 72) of sixty-four residents reviewed.	F 325	F 325 **Brakebill Nursing and Rehabilitation Center supports the standard that based on the resident's comprehensive assessment, the facility must ensure that a resident – maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible: and receives a therapeutic diet when there is a nutritional problem.** **Corrective Action:** **Resident # 41: No opportunity to correct as resident moved out of state to be closer to family.** **Resident # 77: Residents care plan has been reviewed by weight loss team members on 5/2//2013 and updated to reflect weight loss interventions as indicated. Weight loss team members consist of DON, ADON, RNA,**	6/21/13

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F 325	Continued From page 34 The findings included: Resident #41 was admitted to the facility on November 7, 2012, with diagnoses including Dementia, Subdural Hematoma s/p (status post) Fall, Acute Venous Embolism, and Depressive Disorder. Medical record review of the Admission Minimum Data Set (MDS) dated November 14, 2012, and the Quarterly MDS dated February 12, 2013, revealed the resident had severe impairment in cognitive skills, and required limited assistance with one person physical assistance for eating. Medical record review of the physician's recapitulation orders dated April 1, 2013, through April 30, 2013, revealed "...Diet; Regular Chopped Meat, Assist Feeder..." Medical record review of the Nutrition Risk Assessment dated November 14, 2012, revealed "...Wt (weight) (lb) (pounds) 141.8...IBW (Ideal Body Weight)/Usual 83-101...Overall Risk Category:...(greater or equal) 8 points: High Risk." Medical record review of the 24 Hour Diet Assessment (undated) revealed "...Adm. (Admission) Date 11-7-12...Feeding Ability: ...Tray Set up Needs Assistance...Diet History: Current Intake: Solid: Good...Fluid: Good...Nourishments/Supplements: 10:00 AM Choc (chocolate) Ice Cream..." Medical record review of the appetite/supplement form dated 2012-2013 revealed the following weights: November 8, 2012, 141.8 (pounds);	F 325	Medical Records Coordinator, RD, and MDS Assistant. Referral was also made to RD for review on 5/13/2013. Resident # 156: Resident was reviewed by weight loss team members on 5/16/2013. Resident's nutritional concerns will be referred to Registered Dietician for evaluation and recommendations, but due to resident's decreased lack of accepting intake, continued weight loss is still possible and unavoidable. Resident # 159: Resident referred to Registered Dietician on 5/16/3012 by weight loss team for nutritional review, recommendations and interventions to address weight loss. Weight loss team members consist of DON, ADON, RNA, Medical Records Coordinator, RD, and MDS Assistant. Nursing staff will continue to assist resident with all meals x 3 and offer and encourage snacks. Resident # 72: Resident referred to Registered Dietician by weight loss team on 5/2/3013 for nutritional review, recommendations and interventions to address weight loss. Nursing staff will continue to assist resident with all meals x 3 and offer and encourage snacks Identification: Medical record and weight reviews were used by weight loss team members to identify other residents at risk for weight loss. No other residents were identified. Weight loss team members consist of DON,	

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F 325	Continued From page 35 December 28, 2012, 141 (pounds); March, 2013, 126.5 (pounds). Medical record review of the Weights New Admit, Monthly Documentation form revealed the weight on April 24, 2013, was 124.6 (pounds). Review of the facility's Nourishment Sheet revealed the resident received chocolate ice cream at 10:00 a.m., and vanilla ice cream at bedtime. Medical record review of the dietary notes revealed the Registered Dietician (RD) had not assessed the resident since November 14, 2012. Telephone interview on April 24, 2013, at 3:15 p.m., with the contracted RD confirmed the RD had not assessed the resident's weight loss, and the resident had not been placed on the facility's list for the RD to assess related to weight loss. Review of the facility policy, Nutritional Support Program, revealed, "...Residents at risk for weight loss will receive a high calorie supplement during the medication pass...Residents will be placed on and removed from the NSP (Nutritional Support Program) by an MD (Medical Doctor) order: NSP will be documented on the MAR (Medication Administration Record) and refusal will be documented on the PRN (as needed) sheet. Residents on the NSP will receive three ounces of Nutra-Shake twice on the 7-3 shift and twice on the 3-11 shift...The charge nurse on each wing will come to the dietary department and get Nutra-Shake as is needed for his/her medication pass..."	F 325	ADON, RNA, Medical Records Coordinator, RD, and MDS Assistant. Measures to be put in place and systemic changes: Weekly weight loss team meetings consisting of DON, ADON, RNA, Medical Records Coordinator, RD, and MDS Assistant have been initiated on a weekly basis and will continue. Residents identified as having unacceptable weight loss based on weekly or monthly weight review in absence of supporting medical condition will be referred to RD for evaluation and interventions. Director of Nursing/Assistant Director of Nursing will in- service all direct care staff regarding documentation of meal and nourishment's. Intake percentage will be based on and take into account all food, snack and nourishment intakes. In-services will be conducted by DON/ADON within the period allowed in the 2567 or no later than June 22, 2013. Monitoring of corrective actions: Residents at risk for significant weight loss will be reviewed weekly by weight team committee and monitored as an agenda item as a part of facilities monthly QA/QI process beginning 6/1/2013. Weight team committee members consisting of DON, ADON, RNA, Medical Records Coordinator, RD, and MDS Assistant will	

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F 325	Continued From page 36 Interview on April 24, 2013, at 9:00 a.m., with the Dietary Manager, in the training room, confirmed the dietary manager was not aware of the resident's significant weight loss, and was unaware of any interventions in place for the resident's weight loss. Further interview confirmed,"... the facility had not had a dietician for about four months..." Interview on April 24, 2013, at 1:00 p.m., with the Acting Director of Nursing (DON) and the Acting Assistant Director of Nursing, in the training room, confirmed no one is monitoring weights and weight loss since the former RD left, and no review of weight loss residents in daily or weekly meetings, no nutrition at risk teams to review weight loss. Resident #77 was admitted to the facility on March 17, 2011, with diagnoses including Adult Failure to Thrive, Alzheimer's Disease, Dementia, Congestive Heart Failure, Atrial Fibrillation, and Symptoms Concerning Nutrition, Metabolism. Medical record review of the Quarterly Minimum Data Sets (MDS) dated September 10, 2012, and December 7, 2012, revealed the resident was severely cognitively impaired, required extensive assistance with one person physical assistance for eating, and had no weight loss or gain. Medical record review revealed the last nutritional documentation was a progress note dated December 2, 2012, completed by the Registered Dietitian. Further review of the nutritional progress note revealed the resident was not able to self feed and the IBW range was 81-99 pounds.	F 325	make recommendations and referrals to RD for interventions.	

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F 325	Continued From page 37 Review of the weight record revealed the following weights: 1. January 25, 2013, weight 85.8 pounds (#). 2. February 26, 2013, weight 84.1#. 3. March 21, 2013, weight 79.6#. 4. April 25, 2013, weight 74# for a 11.8# weight loss from the January 25, 2013 weight. Review of the physician orders revealed the following: 1. March 26, 2013, Nutritional supplement three times daily due to weight loss; 2. April 2013 Recapitulation Orders signed by the physician April 23, 2013, diet order No Added Salt, Mechanical Soft (texture), Chopped Meat, High Calorie Orange Beverage three times daily and Nutritional supplement 2 ounces three times a day. 3. April 25, 2013, add buttermilk three times daily with meals, and weekly weights for four weeks. Review of the Medication Administration Record for March 2013, and April 2013, revealed no documentation the nutritional supplement had been administered. Medical record review of the Plan of Care dated March 15, 2012, revealed a problem of "...Potential for dehydration and wt (weight)loss d/t (due to) po (by mouth) fluctuation, requires total feeding with the APPROACHES: Enc (Encourage)75-100% of diet, place in upright position for all meals, give bite of food and follow with sip of liquid...offer subs (substitutes) for food refused, food preferences...enc po fluids...monitor weights and intake and document in chart...offer snacks and supplements as ordered..." Further	F 325		

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F 325	Continued From page 38 review of the care plan revealed no changes to the problem or approaches since March 15, 2012. Interview with Certified Nurse Aide #8 on April 30, 2013, at 2:10 p.m., in the resident's room revealed the resident had consumed 100% of the sweet potato, and buttermilk, 50% of the nutritional orange shake, "...best (resident) has eaten in awhile..." Observation on May 1, 2013, at 8:31 a.m., revealed the resident meal delivery cart was on the hall and no tray in the resident's room. Observation continued at 9:21 a.m. revealed the resident had a tray on the over bed table with 10% food intake and 2/3 cup intake of a Mighty Shake (nutritional supplement) mixed with 4 ounces of ice cream. Observation on May 7, 2013, at 8:07 a.m., revealed the resident meal delivery cart was on the hall and no tray in the resident's room. Observation continued at 8:43 a.m. and the Licensed Practical Nurse #10 was feeding the resident a mixture of the Mighty Shake and a 4 ounce container of ice cream. Further observation revealed the resident had eaten 10% of the meal. Interview with the acting Director of Nursing (DON) and the Medical Record Director on April 30, 2013, at 4:12 p.m., in the training room, confirmed the March 2013, and April 2013, Medication Administration Record did not have documentation of the nutritional supplement administration. Further interview revealed the weight loss meeting stopped in February 2013	F 325		

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F 325	Continued From page 39 and resumed April 25, 2013. Interview with MDS Registered Nurse #2 on May 1, 2013, at 8:50 a.m., in the training room, confirmed the March 2013, MDS was not completed, and "...Aware care plans behind..." Interview with the acting DON on May 7, 2013, at 2:25 p.m., in the training room, confirmed the weight loss had not been addressed on the care plan at the time of the loss in January, February, and March 2013. Further interview confirmed no nutritional assessment was completed addressing the weight loss in January, February, and March 2013. Resident # 156 was admitted on November 5, 2012, with diagnoses including Dementia with Behavioral Disturbances, Rheumatoid Arthritis, Diabetes Mellitus, Coronary Artery Disease, Epilepsy (history of seizures, recent onset), Anxiety, Gastroesophageal Reflux Disease, Osteoporosis, Hearing Loss, Hypertension, and Irritable Bowel Syndrome. Medical record review of the admission minimum data set (MDS) dated November 11, 2012, revealed the resident scored seven out of fifteen on the Brief Interview for Mental Status indicating severely impaired cognition. Continued review revealed the resident was dependent on staff with assist of one for eating, personal hygiene, and bathing. Review of the social services note dated November 11, 2012, revealed the resident transferred from an assisted living facility to the long term facility due to needing more care.	F 325		

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F 325	Continued From page 40 Review of the physician's order dated November 6, 2012, revealed, "...Please assist with all feeds - pt (patient) has extremely limited movement RUE (right upper extremity)..." Medical record review of the initial Nutritional Risk Assessment dated November 12, 2012, revealed the resident's admission weight was 103 pounds (lbs.), and had been assessed at being "High Risk" for nutritional decline. Review of the 24 hour Diet Assessment dated November 5, 2012, revealed, "...Nourishments/supplements: 10:00 a.m., Ice Cream." Medical record review of the recorded weights from the meal intake log revealed the resident weighed 101 lbs. on November 20, 2012, and 95 lbs. in December 2012, a significant weight loss of 8 lbs. (7.5 %) in thirty days. Review of the meal intake log for November 2012, revealed the resident's average intake for breakfast was 72%; lunch 54%; and dinner 66%. Review of the resident's lab results revealed an Albumin level of 3.4L (reference range: 3.5 - 5.2) on January 7, 2013, with the physician's signature of confirmation review on January 8, 2013. Observation of meal service in the resident's room on May 1, 2013, at 9:35 a.m., revealed the resident being fed by a certified nurse assistant (CNA). Continued observation revealed the resident was alert, sitting upright in the bed. Continued observation revealed the resident willingly took small bites of food when offered by the CNA.	F 325		

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F 325	Continued From page 41 Interview on May 7, 2013, with Licensed Practical Nurse (LPN) #7 at 8:05 a.m., on the upper 100 hall revealed the staff assisted with feeding of all residents who needed assistance. Continued interview confirmed the resident's willingness and cooperation during feeding varies, stating sometimes the resident will eat well, and sometimes refuses or takes small bites. "Today for example resident would not take medication in one bite, which usually does. It took three spoonfuls to get resident to take all the medication..." Interview with the acting Director of Nursing (DON) on May 6, 2013, at 9:20 a.m., at the 100 hall nurse's station confirmed, the resident had been assessed as high risk on admission; had lost 8 lbs. during the 1st month after admission; there was no documentation the facility assessed the resident for the weight loss; and no interventions were implemented to improve nutrition and prevent further weight loss. Continued interview with the DON confirmed the facility's expectation would be that the resident be placed on weekly weights for close monitoring, and provided nutritional supplements. Resident #159 was admitted to the facility on August 17, 2012 with diagnoses including Chronic Coumadin (blood thinner medication) for Congenital Heart Malfunction, Malaise, Fatigue, Urinary Tract Infection, Dementia, Depression, Congestive Heart Failure and Atrial Fibrillation. Medical record review of the admission MDS dated August 24, 2012 revealed the resident scored 0/15 on the Brief Interview for Mental	F 325		

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F 325	Continued From page 42 Status (BIMS) with severe cognitive impairment; required extensive assistance with all activities of daily living (ADL); and had no significant weight loss. Medical record review of the initial nutrition risk assessment dated August 21, 2012 by the Registered Dietician revealed the resident received a mechanical soft with chopped meat diet and was totally fed by staff. Medical record review of the quarterly MDS dated February 19, 2013 revealed the resident had short and long-term memory problems and moderately impaired decision-making skills; was totally dependent on staff for all ADL; and had no significant weight loss. Medical record review of the weight loss record revealed the resident weighed 163.2 lbs. (pound) on October 26, 2012 and 141.3 lbs. on April 23, 2013-a loss of 21.9 lbs. (13% (percent) weight loss in six months). Medical record review of nurses' notes, dietary notes and physician's progress notes and orders dated August 17, 2012 through April 24, 2013 revealed no weight loss interventions had been implemented. Review of the facility's supplement and nourishment documentation revealed the resident received no nutritional supplements or snacks to address the weight loss. Medical record review of dietary notes revealed the Registered Dietician (RD) had not assessed the resident since August 21, 2012.	F 325		

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F 325	Continued From page 43 Telephone interview on April 24, 2013 at 3:15 p.m. with the contracted RD confirmed the new RD had not assessed the resident's weight loss, and the resident had not been placed on the facility's list for the RD to assess related to weight loss. Medical record review of the weight loss record and interview on April 24, 2013 at 4:25 p.m. in the training room with the acting Director of Nursing and the acting Assistant Director of Nursing confirmed the resident had a weight loss. Continued interview confirmed a RD had not assessed the resident since August 21, 2012, and no interventions had been put in place to prevent significant weight loss. Observation on April 30, 2013, at 7:55 a.m., revealed the resident sitting up in bed being fed a chopped muffin, banana, corn flakes with whole milk, and cranberry juice by Restorative CNA #1. Resident #72 was admitted to the facility on December 10, 2012, with diagnoses including Alzheimer's Disease, Encephalopathy, and Organic Psychotic Condition. Medical record review of the Minimum Data Set (MDS) dated December 17, 2012, revealed the resident had severe impairment in cognitive skills, and required extensive assistance with one person physical assistance for eating. Medical record review of the MDS dated March 9, 2013, revealed the resident had severe impairment in cognitive skills, and was totally dependent with one person physical assistance	F 325		

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F 325	Continued From page 44 for eating. Medical record review of the Nutrition Risk Assessment dated December 17, 2012, revealed, "...Wt (weight) (lb) (pounds) 157...IBW (Ideal Body Weight)/Usual 90-110...Diet order Puree...Overall Risk Category: High..." Medical record review of the appetite/supplement form dated December 2012/2013, revealed the resident weighed a 148.5 pounds in February, 2013, and weighed 138.9 pounds in March, 2013. (6.7% weight loss in one month) Medical record review of a Physician's Order dated January 20, 2013, revealed "...Upgrade diet to mechanical soft chopped meat..." Medical record review of a Monthly Nursing Summary dated February 5, 2013, revealed "...Resident is a total feeder (with) poor intake..." Review of the nourishment sheet (undated) revealed the resident received pudding at 10:00 a.m. Review of the Resident Supplement List revealed the resident does not receive a supplement. Observation on April 30, 2013, at 8:10 a.m., revealed the resident sitting up in bed being fed by CNA #4, a chopped muffin, scrambled eggs, whole milk, oatmeal and cranberry juice. Interview on April 24, 2013, at 2:30 p.m., in the training room, with the acting Assistant Director of Nursing, confirmed the resident had a weight	F 325		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 45 loss and the Registered Dietician (RD) had not assessed the resident since the resident's admission in December 2012. Interview on April 30, 2013, at 9:15 a.m., in the training room, with the acting Director of Nursing (DON), confirmed the full time RD was terminated on January 30, 2013, and the contracted RD's first visit to the facility was on March 26, 2013, and the contracted RD was here for 6 hours per week. Interview on April 30, 2013, at 3:15 p.m. with Restorative CNA #1 and #2, in the training room, confirmed they obtain the resident's weights, and look at the weights from month to month. Further interview confirmed if there is a 5% or greater weight loss in a month they will inform dietary. Continued interview confirmed they would have reported the 6.7% weight loss from February 2013 to March 2013 on Resident #72 to dietary. Interview on May 2, 2013, at 8:50 a.m., in the training room, with the acting DON, confirmed the nourishments on the nourishment sheets come on a separate tray from dietary, and confirmed the intake of the 10:00 a.m. pudding for the resident had not been documented on the meal % intake form. Interview on May 2, 2013, at 10:30 a.m., with Certified Nursing Assistant (CNA) #5, in the hall, confirmed the resident ate 100% of the pudding. C/O TN 31543	F 325		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356		

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	445114	A. BUILDING _____ B. WING _____	05/08/2013

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F 356	Continued From page 46 The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to post accurate nurse staffing information from April 26 through April 29, 2013. The findings included:	F 356	F 356 Brakebill Nursing and Rehabilitation Center supports the posting of the nursing staffing data on a daily basis at the beginning of each shift. Corrective Action: Nursing staffing data has been posted on a daily basis at the beginning of each shift listing the current date, total number and actual hours worked by nursing staff positions as required. Identification: No resident care issues are identified as being adversely affected by the lack of posting of daily nursing staff for the period of April 26 – 29, 2013. Measures to be put in place and systemic changes: Director of Nursing/Assistant Director of Nursing will in-service all unit managers and/or shift supervisors regarding the requirement of posting direct care nursing hours provided on each shift. In-services will be conducted within the period allowed in the 2567 or no later than June 22, 2013.	6/21/13

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F 356	Continued From page 47 Observation on April 29, 2013, at 7:35 a.m., near the main entrance of the facility, revealed the nurse staffing information posted was dated Friday, April 26, 2013. Interview with the acting Director of Nursing (aDON), at the time of the observation, confirmed the staffing information should be updated daily, and the current posting was inaccurate and had not been updated or accurate for three days.	F 356	Monitoring of corrective actions: Visual observations will be utilized to confirm posting of nursing staff requirements each morning for the previous day and current day posting by the DON/ADON and/or shift supervisor. Non-compliance will be reported to manager in charge for correction.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to serve food in a sanitary manner; and failed to maintain the dietary department in a sanitary manner. The findings included: Observation on April 29, 2013, beginning at 12:20 p.m., of the 300 hall revealed two nursing staff taking trays off the resident tray delivery cart and walk down the entire length of the hall passing	F 371	F 371 Brakebill Nursing and Rehabilitation Center ensures that facility must procure food from sources approved or considered satisfactory by Federal, State or local authorities; and should store, prepare, distribute and serve food under sanitary conditions. Corrective Action: Dietary Trays: All food item are covered with an approved, well-fitting lid. Desserts were immediately covered by a saran wrap film upon distribution from the dietary department. Plastic Bowls: Storage procedure was immediately changed to ensure open end of bowls do not come in contact with the tray.	6/21/13

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F 371	Continued From page 48 equipment, medication carts, housekeeping carts, and other residents, visitors and staff. Further observation revealed the desserts on the trays were not wrapped. Interview with Certified Nursing Assistant (CNA) #3 on April 29, 2013, at 12:27 p.m., in the 300 Hallway, confirmed walking a resident's tray the entire length of the hall with unwrapped desserts. Interview with CNA #2 on April 29, 2013, at 12:31 p.m., in the 300 Hallway, confirmed walking the resident's meal tray the entire length of the hall with desserts on the tray which were not wrapped; "...normally the kitchen puts saran wrap on them..." Observation on April 29, 2013, at 12:40 p.m. and 2:55 p.m., in the dietary department revealed, and interview with the Dietary Manager or the Registered Dietitian, present during the observations, confirmed the following: 1. Several trays of plastic bowls were stored on a tray with the open end of the bowl in contact with the tray. Further observation revealed the interiors of the bowls were wet. 2. A dietary staff member was rolling silverware in napkins that were wet and soiled. 3. The can opener in the baker's area, had a blade, base and slot with an accumulation of black sticky debris in the baker area. 4. The floor mixer underside of the beater arm had an accumulation of multi-colored dried debris.	F 371	Silverware and Napkins: Dietary staff members instructed by dietary manager, on same day as discovered, on proper procedure of rolling silverware and to ensure silverware is dry and napkins clean. Can Opener: Opener was immediately cleaned by dietary manager to acceptable, sanitary standards. Floor mixer: Underside of the beater arm was immediately cleaned by dietary manager to acceptable standards. Identification: No identifiable residents could be determined as being affected by conditions noted. Measures to be put in place and systemic changes: Dietary manager immediately held an in-service to communicate to dietary staff results of noted inspection and initiated corrective measures. Cleaning schedule was updated to include inspection and corrective measures to be taken. Monitoring of corrective actions: Monitoring of corrective measures will be initiated by visual observations by dietary manager, shift supervisor(s), and/or lead cook. Registered Dietician will also monitor by sanitation inspections and report any	
F 373 SS=E	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT	F 373		

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F 373	Continued From page 49 A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160: o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following: Feeding techniques.	F 373	compliance observations to dietary manager. Sanitation inspection observations will be reviewed as an agenda item monthly during monthly QA/QI meeting beginning 6/1/2013 F 373 Brakebill Nursing and Rehabilitation Center will ensure that facility training for feeding assistants meets State approved requirements. Corrective Action: State approved feeding assistant training has been identified and will be ordered. Feeding assistants will receive new State approved training as identified by Program Manager before being allowed to assist with feeding. Identification: Two feeding assistants were identified for revised training as a feeding assistant. Measures to be put in place and systemic changes: The State approved training course as identified will be ordered and utilized for current and future feeding	6/21/13

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F 373	Continued From page 50 Assistance with feeding and hydration. Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control. Resident rights. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse. A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants. This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility paid feeding assistant course curriculum, and interview the facility failed to provide a State-approved training program for two of two paid feeding assistants. The findings included: Observation on May 5, 2013 at 12:40 p.m., on the 300 Hall, revealed a paid feeding assistant sitting at resident #187's bedside, feeding the resident a mechanically altered meal. Interview with the feeding assistant, at the time of the observation, revealed the feeding assistant completed feeding assistant training in the facility, in February 2013. Continued interview revealed	F 373	assistants. Requirements for the program will be followed and documented for each assistant who participates in the program. Training will be conducted by appropriate licensed personnel. Feeding assistants will not be utilized until State approval is obtained for program and staff receives approved training. Monitoring of corrective actions: Compliance and passage of approved training will be documented and reviewed by the Director of Nursing as evidence of completion. Results will be made a part of employee's education and training file for inspection and review.	

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F 373	Continued From page 51 the feeding assistants work on one of four halls at staggered shifts for meal coverage A copy of the training curriculum for the two paid feeding assistants, trained in the facility, in February 2013, was requested and reviewed. The Program Manager (PM) for State course credentialling was contacted by email, on May 6, 2013, at 1:52 p.m., and the PM verified the facility did not have a State-approved paid feeding assistant program. Interview with the acting Director of Nursing (aDON) and acting Assistant Director of Nursing (aADON) on May 6, 2013, at 1:05 p.m., at the 300 hall nursing station, confirmed the facility employs two staff members for the sole purpose of assisting dependent residents with meals. The paid feeding assistants completed in-house training in February 2013, but the curriculum was not a State-approved feeding assistant course. The DON and ADON stated they were unaware the curriculum was not a State-approved course, and they verbalized understanding during the interview, that no facility staff could assist with resident feeding without having completed a State-approved feeding course.	F 373		
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced	F 505	F 505 Brakebill Nursing and Rehabilitation Center supports the requirement that a physician be promptly notified of lab results.	6/21/13

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F 505	Continued From page 52 by: Based on medical record review and interview, the facility failed to promptly notify the physician of lab results for one resident (#78) of sixty-four residents reviewed. The findings included: Resident #78 was admitted to the facility on June 22, 2012 with diagnoses including Dementia, Epilepsy, Depression, Dysphagia, and Affective Psychosis. Medical record review revealed a physician order dated April 1, 2013 "...CBC (complete blood count)/B12 (vitamin B 12)/Folate/PAB (prealbumin)/Dilantin (anti-seizure medication) level/Depakote (mood stabilizer) level on 4-2-13..." Medical record review of medication regimen review from pharmacy revealed, "...4-10-13...depakote and Dilantin level ordered but not in the chart..." Medical record review of medication regimen review from pharmacy revealed, "...4-30-13...still need Depakote and Dilantin level..." Medical record review revealed no lab results for Dilantin or Depakote were in the chart. Interview with the acting Director of Nursing (DON) on May 1, 2013, at 2:00 p.m., at the 200 Hall nurse station, confirmed no lab results for Dilantin or Depakote were present in the resident's chart. Continued interview with the DON, at that time, confirmed the lab results were	F 505	Corrective Action: Resident # 78: No opportunity to correct dates for lab results for this resident. Lab results were obtained on May 1, 2013 and physician was notified of results at that time. Identification: Upon record review by unit secretaries, no other resident as was identified as having outstanding lab results. Measures to be put in place and systemic changes: Nursing Director/Assistant Director of Nursing will in- service all unit secretaries, unit managers and/or shift supervisors regarding the requirement of reviewing all orders for acquisition of resident labs and to note in lab log when results are obtained. Unit secretaries will report receipt of lab results to licensed staff member for physician notification. In-services will be conducted within the period allowed in the 2567 or no later than June 22, 2013. Monitoring of corrective actions:	

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F 505	Continued From page 53 not obtained by the facility or reviewed by the physician until May 1, 2013, and confirmed a month delay in notification of physician of lab results.	F 505	**Unit managers and/or shift supervisor notify shift supervisor of any outstanding lab results pending which will be communicated to relieving supervisor for follow-up and physician notification. Unit secretaries and/or unit manager will review lab logs each shift and will notify DON/ADON and/or supervisor of any results still pending after 24 hours unless lab has been flagged as a stat result. Compliance will be reported monthly by DON/ADON during QA/QI Meeting beginning 6/1/2013.**	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain a complete medical record for one (#77) resident of sixty-four reviewed. The findings included: Resident #77 was admitted to the facility on March 17, 2011, with diagnoses including Adult Failure to Thrive, Alzheimer's Disease, Dementia, Congestive Heart Failure, and Atrial Fibrillation.	F 514	**F 514** **Brakebill Nursing and Rehabilitation Center supports the requirement that a facility must maintain clinical records on each resident in accordance with acceptable professional standards and practices.** **Corrective Action:** **Resident # 77: Laboratory services provider contacted by unit secretary to resend lab results for the dates indicated to be filed in residents chart.** **Identification:** **Record review indicated no other resident records did not contain laboratory studies as ordered.**	6/1/13

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F 514	Continued From page 54 Medical record review of physician phone orders revealed laboratory studies were ordered and laboratory results were to be obtained on March 19, 2013, and April 15, 2013. Interview with the Director of Nursing and the Medical Record Director, on April 30, 2013, at 4:12 p.m., in the training room, confirmed the medical record failed to contain the March 19, 2013, and April 15, 2013, laboratory information.	F 514	**Measures to be put in place and systemic changes:** **Unit secretaries and/or unit manager will review lab logs each shift and will notify DON/ADON and/or supervisor of any results still pending after 24 hours unless lab has been flagged as a stat result. Unit secretary will assume responsibility for filing lab results in the medical record following physician notification by licensed nursing staff. Procedure will be communicated to nursing staff through an in-service conducted by DON/ADON. In-services will be conducted within the period allowed in the 2567 or no later than June 22, 2013. Compliance will be reported monthly by DON/ADON during QA/QI Meeting beginning 6/1/2013.**	